

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000165	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/08/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-GOLDEN RULE		STREET ADDRESS, CITY, STATE, ZIP CODE 2330 STRAIGHT LINE PIKE RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health.</p> <p>Survey Date: 11/08/12</p> <p>Facility Number: 000165 Provider Number: 155264 AIM Number: 100288220</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Quality Assurance Walk-thru survey, Golden Living Center-Golden Rule was found in compliance with 410 IAC 16.2-3.1-19(ff).</p> <p>This one story facility was determined to be of Type V (000) construction in the 1973 original portion of the facility and Type V (111) construction in the south portion of the building, constructed in 1983, including the South Wings and Medicare Suite Wing. The facility is fully sprinklered and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 170 and had a census of 134 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except three detached buildings; a sixteen foot by twenty four foot wooden storage shed, and two, ten foot by twelve</p>	S 000		

Indiana State Department of Health

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

ILD821

If continuation sheet 1 of 2

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S 000	Continued From page 1 foot wooden storage sheds which were not sprinklered.	S 000			